Application for

Affordable HEALTH CARE

For Children, Teens and Pregnant Women

A Healthier Tomorrow Starts Today

Provided by the State of California

A Healthier Tomorrow...

Two Programs

Healthy Families
For Children
Ages 1 year up to 19...

Medi-Cal
For Children under 19
And Pregnant Women

STEPS 1 AND 2
To Estimate Your Family's Income

STEP 3
Qualifying for Healthy Families and Medi-Cal

PART A
Application for Health Care

PART B
Healthy Families Program
For Children Only
Age 1 year to 19th birthday

PART C
Medi-Cal Program
For Children from Birth to 19th birthday
OR
Medi-Cal Program
For Pregnant Women

Please put the applications for each program in separate envelopes.
You must include Steps 1,2, 3 and Part A with each application packet.
Then, just drop your completed application packet in the mail.

...Starts Today

Highlights

HEALTHY FAMILIES PROGRAM:

- Provides low-cost health, dental and vision insurance for children 1 year old up to age 19
- Provides comprehensive health, dental and vision benefits
- Gives a choice of private health, dental and vision insurance plans
- Offers low monthly premiums from as low as $4 per child to a maximum of $27 per family
- Limits copayments to $250 per year per family for health services and has $5 copayments for non-preventive services (such as going to the doctor due to illness)
- Does not require copayment for preventive services such as immunizations
- Covers children without health insurance and those with share-of-cost Medi-Cal
- Eligibility is determined by family income every year
- Parents can use either:
  a) The income of the parent the children live with; *or*
  b) The income of the parent the children do not live with
- Does NOT count family resources (such as bank accounts or cars)
- Allows applicants to mail application

MEDI-CAL: A NEW *MAIL-IN* APPLICATION FOR CHILDREN UP TO AGE 19 AND PREGNANT WOMEN

- Covers more children than ever before up to age 19 with higher family incomes
- Provides comprehensive health, dental and vision benefits for children up to age 19
- Family resources (such as bank accounts or cars) do not count for eligibility, but family income does
- Covers pregnancy related services for women, which include: family planning, prenatal care, labor and delivery and post-partum care
- Healthy Families premium can be used to reduce other family members' Medi-Cal share of cost

Inside

WE'RE HELPING CHILDREN AND PREGNANT WOMEN GET AFFORDABLE HEALTH CARE. TO APPLY, FOLLOW THESE STEPS...

1 Start Here!

Estimate your family's income/earnings. STEP 1 will help you with your figuring.

2 Find Out!

Which program you or your children qualify for by completing STEP 2 and STEP 3, on pages 9 and 10.

6 For Medi-Cal ...

Fill out FORM MC 13 and, if needed, CA2.1, with CA2.1(Q), and send required verifications (proof). See page 23 for a list of acceptable proof.

7 You're Almost Finished. Just Double Check ...

All you need to *do* now is to check that you have everything you need to send along with your application.

I am applying for Healthy Families for my children and/or myself (18 year old).

I am enclosing:

- ☐ Steps 1, 2, 3
- ☐ Part A
- ☐ Part B
- ☐ Proof of Child(ren)'s Alien Status
- ☐ Proof of Child(ren)'s U.S. Citizenship (If you do not have the document now to prove status, you may submit it within 60 days from the date of enrollment)
- ☐ Proof of Income
- ☐ Money Order or Cashiers Check

I am applying for Medi-Cal for Children and Pregnant Women.

I am enclosing:

- ☐ Steps 1, 2, 3
- ☐ Part A
- ☐ Part C
- ☐ MC 13
- ☐ CA2.1 and CA2.1(Q) if needed
- ☐ Proof of Identity of Applicant
- ☐ Proof of Income and Deductions
- ☐ Proof of Pregnancy from the doctor or clinic
- ☐ Evidence of Residency
- ☐ Proof of Alien Status

3 For Medi-Cal and Healthy Families...

When you apply for either program, complete PART A.

4 For Healthy Families...

Complete PART B. And please be sure to send proof of your income, U.S. citizenship or alien status and a money order or cashiers check to pay your premium. See page 18 for more details.

5 For Medi-Cal for Children and Pregnant Women...

Complete PART C.

6 You're Finished...

Have you filled everything out completely and correctly? Have you enclosed copies of everything you need to send along with your application? Have you put the forms and the other information in the envelopes provided? There is an envelope for each program. Be sure the program you are applying for matches the envelope for that program.

If you have more than one child, each child can qualify for a different program. If you apply to one program for one child and the other program for a second child, you must send STEPS 1, 2, 3 and PART A to each program (Healthy Families and Medi-Cal). Photocopies of your originals are okay. Sign each copy because they go to different places.

Just put it in the mail!

Answers to Questions You May Have

1. **How do I find out which program(s) I should apply for?**

   Use the forms "STEP 1: Getting Started" on page 7, "STEP 2: Family Income Estimate Form" on page 9, and "STEP 3: Qualifying for Healthy Families and/or Medi-Cal" on page 10 to help find out which program(s) you or your children may apply for.

2. **What if I apply for the wrong program?**

   Once your completed application is mailed in, if it is found that you applied for the wrong program, your application may be forwarded to the correct program. **We must have your permission before your application can be forwarded.** Be sure to check the box on the top portion of Part A – Application for Health Care (page 11). If your application is forwarded to the other program, you will receive a notice in the mail, and you may receive additional forms to fill out.

3. **Can one family have children in both programs at the same time?**

   Yes. Your family income and the age(s) of the child(ren) will help you figure out which program(s) to apply to for each child.

4. **If my child(ren) is a citizen of the United States and I am not, can I get health care coverage for my child(ren)?**

   Yes, you can, if your child(ren) meets all other eligibility rules.

5. **If my child(ren) is an alien(s), can he/she apply for health care coverage through the Healthy Families or Medi-Cal Program?**

   Many aliens can qualify.
   - For Healthy Families, a person must be an eligible qualified alien. The Healthy Families Program Handbook explains which aliens may be eligible. Call 1-800-880-5305 to receive a copy.
   - For Medi-Cal, if they meet Medi-Cal eligibility rules, legal immigrant children can qualify for full benefits no matter when they entered the U.S., and undocumented children can get emergencies covered. Contact your local county welfare office.

6. **What if I make too much money to qualify for a government program?**

   - Be sure to use the "Step 2: Family Income Estimate Form" and "Step 3: Qualifying for Healthy Families and/or Medi-Cal" before deciding your income is too high.
   - Certain types of income are not counted (page 6).
   - There are several Medi-Cal deductions you may be able to take (page 9).
   - If you've completed the above forms and your income still seems too high, you may call the toll-free numbers listed in this booklet or your local county welfare office for further assistance and information. You may be eligible for no-cost or share-of-cost Medi-Cal.

7. **What if I want to apply for Medi-Cal for persons in my family other than pregnant women or children under 19?**

   Please apply at your local county welfare office. Even if your income is over the Federal Income Guideline chart (page 10) for your family size, you may still qualify for one of the Medi-Cal programs.

8. If my child(ren) is currently covered through an employer, can I apply for Healthy Families?

In general, your child(ren) is not eligible for the Healthy Families Program if the child is covered today by an employer's health plan or has been covered in the past 90 days. Refer to the Healthy Families Program Handbook which is a separate packet for a list of exceptions to this rule. Call 1-800-880-5305 to receive a copy.

9. Who can help me complete this application?

Many community organizations have been trained to help you apply for Healthy Families Program or Medi-Cal. You do not have to pay for this help. It is FREE! Look for the logo on the cover or call 1-888-747-1222 for assistance.

10. How long will it take before I know if I qualify?

- For **Healthy Families:**
  You will be notified by mail within 20 days from the date a **completed** application is received. You may call 1-800-880-5305 to ask about the status of your application.

- For **Medi-Cal:**
  You will be notified by mail within 45 days from the date the county welfare office receives your application.

11. Is there any place else I can apply for Medi-Cal besides the county welfare office?

Yes, in some counties, you can apply for Medi-Cal and meet with county eligibility staff at outstation sites such as community clinics. Check with your local county welfare office for those clinic locations.

12. Do I have to apply for Healthy Families and/or Medi-Cal for children and pregnant women in person?

No, you can mail the application!
For Medi-Cal, you may still meet with a county worker if you want to.

13. Can I get health care if I am pregnant and have no health insurance and do not qualify for no-cost Medi-Cal?

Yes. The Access for Infants and Mothers (AIM) program provides health care to pregnant women with no health insurance for their pregnancy or who do not qualify for no-cost Medi-Cal. After the baby is born, the AIM program provides health care to the baby for up to two years. If you would like more information, call 1-800-433-2611.

Mailing address:
AIM Program,
c/o Healthcare Alternatives,
P.O. Box 15248,
Los Angeles, CA 90015

14. What if my family makes too much money to qualify for no-cost Medi-Cal?

Members of your family could still get Medi-Cal with a share of cost. Share of cost is the monthly amount some families pay (or promise to pay) towards their health care cost before Medi-Cal will pay. A family's monthly share of cost may change when their monthly income changes. Families do not need to pay a share of cost in months during which they do not get medical care. A child who is eligible for Medi-Cal with a share of cost may qualify for Healthy Families and other family members can stay on Medi-Cal with a share of cost. You may apply for share-of-cost Medi-Cal at your local county welfare office.

15. What happens to my Medi-Cal if I lose my cash aid (AFDC or CalWORKs) because I get married, return to live with my spouse or get a job?

You could still continue Medi-Cal benefits for up to 12 months. This program is called Transitional Medi-Cal. For more information contact your local county welfare office.

Who Is Considered A Family Member?

Every time we use the words "parent(s)" or "child(ren)" we mean natural parent(s) or adoptive parent(s) and natural child(ren) or adopted child(ren).

ADULTS

- You, the applicant; **or**
- Your spouse; **or**
- Your child's parent who is living with you, even though you may not be married; **or**
- For the Healthy Families Program, the parent who lives with the child(ren) if you are using the child(ren)'s household income to qualify.

PLEASE NOTE:

Caretakers, foster parents and legal guardians ARE NOT listed as family members on Step 1 because their income is not counted.

*If a stepparent is **not** applying for his or her child(ren), do not list the stepparent's name and income on Step 1.*

CHILDREN

- Your child(ren) under 21, who is living with you or away at school and claimed as your tax dependent
- Your spouse's child(ren) under 21, who is living with you or away at school and claimed as your spouse's tax dependent
- The other parent's child(ren) under 21, who is living with you or away at school and is claimed as the other parent's tax dependent
- Your unborn child

What Income Counts?

- Earnings from a job including cash, wages, salary, commissions and tips
- Self-employment net profits
- Government benefits such as Social Security Retirement Survivor Disability Insurance (RSDI), Veterans, Railroad Retirement, Disability, Worker's Compensation, Unemployment, etc.
- Child support
- Alimony/spousal support
- Pensions or retirement
- Other income including, but not limited to, grants for living expenses, settlement benefits, rental net profit, gifts, lottery/bingo winnings and interest income

What Income Does Not Count?

- Supplemental Security Income/State Supplementary Program (SSI/SSP) payments.
- Foster care payments
- CalWORKs (replaces the former AFDC program) payments
- General relief payments
- Grants or scholarships used for college expenses
- Earnings from a job of a child under age 14 **or** a child attending school
- Some government benefit payments – please check with your local county welfare office

Step 1: Getting Started - To Estimate Your Family's Income

Please check the box which indicates the household income you are using to qualify for Healthy Families

☐ Applicant's household ☐ Children's household

1. Use the boxes below to figure out the **MONTHLY** gross income/earnings **(before taxes)** for each adult family member.
2. Use one column for each person. Write the gross income/earnings in the correct box(es) for how often you are paid. If the adult family member has no income, write "none" in the box.
3. Write the source of income where indicated. For example, name of employer (job), social security, retirement.
4. Include any alimony received on line F.
5. If you have more than 2 adult family members, make and use copies of this page.

INCOME	1. APPLICANT NAME:		2. OTHER ADULT IN THE HOME NAME:	
A. Weekly	$ _____ x 4.33 =	A.	$ _____ x 4.33 =	A.
Where is Income from?				
B. Every 2 weeks	$ _____ x 2.167 =	B.	$ _____ x 2.167 =	B.
Where is Income from?				
C. Twice Monthly	$ _____ x 2 =	C.	$ _____ x 2 =	C.
Where is Income from?				
D. Monthly	$ _____ x 1 =	D.	$ _____ x 1 =	D.
Where is Income from?				
E. Yearly	$ _____ ÷ 12 =	E.	$ _____ ÷ 12 =	E.
Where is Income from?				
F. Alimony Received	$ _____ x 1 =	F.	$ _____ x 1 =	F.
Where is Income from?				
Totals	Add boxes A - F	$	Add boxes A - F	$

Transfer these totals to Family Income Box, page 9.

For Healthy Families, call toll-free: 1-800-880-5305. For Medi-Cal, call toll-free: 1-888-747-1222

Step 1: Getting Started - To Estimate Your Family's Income *(continued)*

Please check the box which indicates the household income you are using to qualify for Healthy Families

☐ Applicant's household ☐ Children's household

1. Use the boxes below to figure out the **MONTHLY** gross income/earnings **(before taxes)** for each child.
2. Use one column for each child. Write the gross income/earnings in the correct box(es) for how often the child is paid. If the child has no income, write "none" in the box.
3. Write the source of income where indicated. For example, name of employer (job), social security, retirement.
4. If a child receives child support, put it on line F.
5. If you have more than 3 children, make and use copies of this page.

INCOME	3. CHILD A NAME:		4. CHILD B NAME:		5. CHILD C NAME:	
A. Weekly	$ _____ x 4.33 =	A.	$ _____ x 4.33 =	A.	$ _____ x 4.33 =	A.
Where is Income from?						
B. Every 2 weeks	$ _____ x 2.167 =	B.	$ _____ x 2.167 =	B.	$ _____ x 2.167 =	B.
Where is Income from?						
C. Twice Monthly	$ _____ x 2 =	C.	$ _____ x 2 =	C.	$ _____ x 2 =	C.
Where is Income from?						
D. Monthly	$ _____ x 1 =	D.	$ _____ x 1 =	D.	$ _____ x 1 =	D.
Where is Income from?						
E. Yearly	$ _____ ÷ 12 =	E.	$ _____ ÷ 12 =	E.	$ _____ ÷ 12 =	E.
Where is Income from?						
F. Child Support Received	$ _____ x 1 =	F.	$ _____ x 1 =	F.	$ _____ x 1 =	F.
Where is Income from?						
Totals	Add boxes A - F	$	Add boxes A - F	$	Add boxes A - F	$

Transfer these totals to Family Income Box, page 9.

For Healthy Families, call toll-free: 1-800-880-5305. For Medi-Cal, call toll-free: 1-888-747-1222

MC 320 (6/98)

MC 350 (exps)

Step 2: Family Income Estimate Form

You must have the information from Step 1 to fill out this form. Complete this form to find out if you or your child(ren) should apply for Healthy Families and/or Medi-Cal.

Family Income *(from pages 7 and 8).*

Names of family members	Amount of Monthly Income *(from STEP 1)*	Names of family members	Amount of Monthly Income *(from STEP 1)*
1. Applicant	$	6.	$
2. Other Adult	$	7.	$
3. Child A	$	8.	$
4. Child B	$	9.	$
5. Child C	$	10.	$

Put the total number of people you list above here →

Box A Circle the number of family members on chart 1, page 10

Box B Add lines 1 through 10. Put this number in the Healthy Families box in Chart 2, page 10.

Deductions for Medi-Cal only

1. Work expense

Up to a $90 deduction is given for each working person in your family. If a person earns less than $90, the deduction for that person can only be the amount he/she earns. If a person's income is not counted, you may not take the work expense deduction for that person.

Add the allowable work expenses for your family. ..... 1. $

2. Child care expenses you pay monthly

Child care and dependent care expenses while you work or train for a job are deducted if you do not have someone at home who can provide child care.

The maximum monthly deduction for **each** child or dependent follows:

- Under the age of 2 ..... $200
- Over the age of 2 ..... $175
- A disabled dependent $175

Enter total on line 2. ..... 2. $

3. Alimony you pay monthly ..... 3. $

4. Child support you pay monthly ..... 4. $

5. If you get child support/alimony, deduct $50 ..... 5. $

$

Box C Add lines 1 through 5

THIS SHEET PROVIDES AN ESTIMATE ONLY AND DOES NOT GUARANTEE ELIGIBILITY FOR EITHER HEALTHY FAMILIES OR MEDI-CAL.

Box B - Box C = (Box B minus Box C) $

Box D Put this number in the Medi-Cal boxes in Chart 2, page 10.

For Healthy Families, call toll-free: 1-800-880-5305. For Medi-Cal, call toll-free: 1-888-747-1222

Step 3: Qualifying for Healthy Families and/or Medi-Cal

CHART 1 - FEDERAL INCOME GUIDELINE CHART

Circle your family size (Count unborn child as a family member)	COUNTABLE INCOME		
	A	B	C
1	$671	$893	$1,342
2	$905	$1,203	$1,809
3	$1,138	$1,513	$2,275
4	$1,371	$1,824	$2,742
5	$1,605	$2,134	$3,209
6	$1,838	$2,444	$3,675
7	$2,071	$2,755	$4,142
8	$2,305	$3,065	$4,609
9	$2,538	$3,375	$5,075
10	$2,771	$3,686	$5,542

EFFECTIVE APRIL 1998
THIS FEDERAL INCOME GUIDELINE CHANGES EACH YEAR IN APRIL. BE SURE TO GET AN UPDATED CHART AFTER APRIL 1 EACH YEAR.

CHART 2 - HEALTH CARE PROGRAMS

List pregnant woman and Child(ren) name(s) below under their age group	NO-COST MEDI-CAL	HEALTHY FAMILIES	SHARE-OF-COST MEDI-CAL
	$ _____ from box D, page 9	$ _____ from box B, page 9	$ _____ from box D, page 9
	You must apply for no-cost Medi-Cal if your income is:	Apply for Healthy Families if your income is:	Or apply for Share-of-Cost Medi-Cal at your local county welfare office if your income is:
Less than 1 year _____ _____	less than column C in Chart 1	Not Applicable	more than column C in Chart 1
1 to 6 years _____ _____	less than column B in Chart 1	between columns B & C in Chart 1	more than column C in Chart 1
6 to 19 years _____ _____	less than column A in Chart 1	between columns A & C in Chart 1	more than column C in Chart 1
Pregnant Woman and Unborn child _____	less than column C in Chart 1	Not Applicable	more than column C in Chart 1 OR apply for Access for Infants and Mothers (AIM)

Your family size and income decide which program you or your child(ren) may apply for. **If you can get no-cost Medi-Cal, you cannot get Healthy Families.**

First, to find out if you or your child(ren) can get no-cost Medi-Cal, you must do the following:

- Go to Chart 1, circle your family size. You will come back to this line.
- Go to Chart 2, put each child's name or pregnant woman's name in the correct group.
- Look at the no-cost Medi-Cal column directions in Chart 2 for each person listed.
- Find out if you or your child(ren) can get no-cost Medi-Cal based on your income listed in this column. If yes, apply for no-cost Medi-Cal. If no, continue.

Second, if you cannot get no-cost Medi-Cal, to find out if you or your child(ren) can get Healthy Families, you must do the following:

- Go to Chart 1, circle your family size. You will come back to this line.
- Go to Chart 2, put each child's name in the correct group.
- Look at the Healthy Families column directions in Chart 2 for each person listed.
- Find out if you or your child(ren) can get Healthy Families based on your income listed in this column. If yes, apply for Healthy Families. If no, continue.

Third, if you or your child(ren) cannot get no-cost Medi-Cal or Healthy Families, you may still be able to get share-of-cost Medi-Cal or AIM.

PLEASE NOTE:
If your family income is more than the amounts on Chart 1 for your family size, you or your children may still qualify for Medi-Cal benefits with or without a share of cost. Income is counted differently for some family members such as:

- Permanently disabled person
- Stepparent
- Child with own income

Contact your local county welfare office for help.

For Healthy Families, call toll-free: 1-800-880-5305. For Medi-Cal, call toll-free: 1-888-747-1222
For Access for Infants and Mothers call toll-free: 1-800-433-2611.

MC 324A (6/98)

Part A: Application for Health Care-Healthy Families and/or Medi-Cal

If you are applying for more than one program, you will need to copy this form and send one with each application packet.

Please check the box next to the program you are applying for.

☐ **HEALTHY FAMILIES**

If you or your child(ren) are not eligible for Healthy Families, do you want this application forwarded to the Medi-Cal Program?

☐ No ☐ Yes

☐ **MEDI-CAL PROGRAM**

If we find your income gives your child(ren) under 19 share-of-cost Medi-Cal, do you want this application forwarded to the Healthy Families Program?

☐ No ☐ Yes

☐ **MEDI-CAL FOR PREGNANT WOMEN**

If you are pregnant, and eligible for share-of-cost Medi-Cal, do you want this application forwarded to the Access for Infants and Mothers (AIM) Program?

☐ No ☐ Yes

SECTION 1: Applicant Information

1. Applicant's Name _____ (Last) _____ (First) _____ (Middle)
2. Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Never Married ☐ Separated
3. Home Address _____ (Street) _____ (City) _____ (County) _____ (Zip Code)
4. Mailing Address (if different) _____ (Street/P.O. Box) _____ (City) _____ (County) _____ (Zip Code)
5. Home Phone (_____ (Area Code)) _____ Work Phone (_____ (Area Code)) _____
6. Phone number where a message may be left (_____ (Area Code)) _____
7. What language(s) do you speak? _____

SECTION 2: General Information

The answers to these questions will help us provide more services for you.

1. Does anyone applying for benefits have a life threatening medical condition?
   ☐ No ☐ Yes
   If yes, who: _____
2. Is anyone applying for benefits pregnant?
   ☐ No ☐ Yes
   If yes, who: _____ Due Date _____
3. Does anyone applying for benefits have an urgent health care need?
   ☐ No ☐ Yes
   If yes, who: _____
4. Are any members of your family living in your home blind or disabled?
   ☐ No ☐ Yes
   If yes, who: _____
5. Do you want more information about the Access for Infants & Mothers (AIM) Program "For pregnant women only"?
   ☐ No ☐ Yes
6. Do you want information about services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC)?
   ☐ No ☐ Yes

SECTION 3: Past Medical Costs

1. Has a family member had medical costs in the last 3 months? Medi-Cal may be able to help you pay for these costs.
   ☐ No ☐ Yes
2. Does that person want to apply for Medi-Cal coverage for the 3 prior months?
   ☐ No ☐ Yes
   If yes, who: _____
   Requesting coverage for month(s): _____

Please complete and sign the back of this form .

Part A: Application for Health Care-Healthy Families and/or Medi-Cal *(continued)*

1. For children: fill out Sections 4 and 5, #1-14 in the child column.
2. For Healthy Families, the adult applying for his/her children, fill out Section 4, #1-4 in the applicant column.
3. For Healthy Families, an 18 year old applying for him/herself, fill out Sections 4 and 5, #1-13 in the applicant column.
4. For Medi-Cal, the adult applying for his/her children, fill out Section 4, #1-7 in the applicant column. If there is another parent in the home, fill out #1-8 for the other parent in the other adult column .
5. For Medi-Cal, a pregnant woman applying for pregnancy related services, fill out Sections 4 and 5, #1-13 in the applicant or other adult column.
6. For children receiving CHDP services, put the claim number on line 12.

SECTION 4	APPLICANT	OTHER ADULT	CHILD A	CHILD B	CHILD C
1. Please check programs applying for:	☐ Healthy Families ☐ Medi-Cal ☐ None	☐ Healthy Families ☐ Medi-Cal ☐ None	☐ Healthy Families ☐ Medi-Cal ☐ None	☐ Healthy Families ☐ Medi-Cal ☐ None	☐ Healthy Families ☐ Medi-Cal ☐ None
2. Name: Last					
First					
Middle					
3. Sex:	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
4. Ethnic Code (See page 28):	For Healthy Families Program				
5. Social Security Number: (optional for Healthy Families)	Fill Out Only if				
6. Date of Birth: mo/day/year	This Person Wants Benefits				
7. Birthname (if different): Last					
First/Middle					
8. Relationship to applicant:	*Not Applicable*				
SECTION 5					
9. Place of Birth: County/State/Country	For Healthy Families				
10. Mother's Name: Last	And Medi-Cal Programs				
First/Middle	Fill Out Only if				
11. Father's Name: Last	This Person Wants Benefits				
First/Middle					
12. CHDP Service Claim # in the last 30 days	#	#	#	#	#
13. Does this person have a Medi-Cal Benefits Card (BIC)? If yes, give BIC #:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	#	#	#	#	#
14a. Does child live with applicant?	*Not Applicable*		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14b. If No, write address: Street					
City/State/Zip					

12

SECTION 6

▶ Applicant Signature X _____ Date _____

MC 321B (0398)

Part B: Application for the Healthy Families Program

Please fill out both sides of this form to continue your application for the Healthy Families Program.
If you are applying for more than 3 children, make copies of all pages of Part B.

Please check the box which indicates the household income you are using to qualify for Healthy Families

☐ Applicant's household ☐ Children's household

SECTION 1: Other Health Coverage	18 years old applying for self Last Name First Name	Child A Last Name First Name	Child B Last Name First Name	Child C Last Name First Name
1. Did any person applied for have health insurance coverage through an employer in the last 90 days? *If you answered yes, provide the following information:* When did the insurance end for each person? Name of the health plan: _____ Check the box next to the reason the person is not now, or will no longer be covered by an employer's health insurance: ☐ Loss of employment ☐ Address change where there is no coverage ☐ Employer discontinued benefits to all employees ☐ COBRA coverage expired ☐ Other _____	☐ Yes ☐ No Date	☐ Yes ☐ No Date	☐ Yes ☐ No Date	☐ Yes ☐ No Date
2. Is any person(s) applied for enrolled in no-cost Medi-Cal? *If you answered yes,* provide the date the coverage will end for each person.	☐ Yes ☐ No Date	☐ Yes ☐ No Date	☐ Yes ☐ No Date	☐ Yes ☐ No Date
3. In the last six months was any person applied for enrolled in the Healthy Families Program? *If you answered yes, please indicate if one of the reasons benefits terminated in Healthy Families was for:* ☐ Loss of employment in family ☐ Catastrophic illness in family so you could not work for 2 weeks or more ☐ Person applied for became eligible for no-cost Medi-Cal	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Does your employer offer health insurance for the person(s) being applied for? (Your answer to this question will not affect your eligibility.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

For Healthy Families, call toll-free: 1-800-880-5305.

Part B: Application for the Healthy Families Program *(continued)*

SECTION 2: Choice of Health, Dental and Vision Plan Combination and Providers

PLANS - (Insurance Company)

Choose from the health, dental and vision **plan** combinations listed under the County where the person(s) being applied for lives. You may only select one plan combination per household. **If you do not choose a plan combination, Healthy Families will return your application.**

Please refer to the Healthy Families Program Handbook for help in filling out this section. Descriptions of the Healthy Families Plan combinations and ideas to help you choose a plan that is best for the person(s) applied for are in the Healthy Families Program Handbook. Call 1-800-880-5305 for a copy of the handbook, or for information on the providers available through each of the Healthy Families plans.

HOUSEHOLD 1 - Plan Code: _____

Health Plan: _____

Dental Plan: _____

Vision Plan: _____

If you do not choose a health, dental, and vision plan combination, your application will be returned.

HOUSEHOLD 1- **Providers/Clinics** (If you do not choose here, the plan you selected above may contact you or may choose a provider for you.)

Name of Child	Health Provider/Clinic	Code	Dental Provider/Clinic	Code
1.				
2.				
3.				
4.				

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HOUSEHOLD 2 - Plan Code: _____
(If needed)

Health Plan: _____

Dental Plan: _____

Vision Plan: _____

If you do not choose a health, dental, and vision plan combination, your application will be returned.

HOUSEHOLD 2- **Providers/Clinics** (If you do not choose here, the plan you selected above may contact you or may choose a provider for you.)

Name of Child	Health Provider/Clinic	Code	Dental Provider/Clinic	Code
1.				
2.				
3.				
4.				

Part B: Application for the Healthy Families Program *(continued)*

SECTION 3: Declarations—Applicant Must Initial Each Statement

____ 1. I have read and understand the **Healthy Families Program Handbook** as well as the individual health plan descriptions and benefits offered.

____ 2. I declare that I am either an 18 year old applying for myself or that I am applying for all of my child(ren) who meet the requirements of the **Healthy Families Program**, unless they are already enrolled.

____ 3. I declare that each person(s) I am applying for on this application is **not** eligible for **Medicare Part A** and **Part B.**

____ 4. I declare that each person(s) I am applying for on this application lives in the state of California.

____ 5. I declare and understand that I and each person(s) I am applying for on this application will follow all the rules and requirements of the **Healthy Families Program**.

____ 6. I declare that each person(s) I am applying for on this application is not a member of a family that is eligible for health benefits from the California Public Employees Retirement System Health Benefits Program(s).

____ 7. I declare that each person(s) I am applying for on this application is not in jail or is not a patient in a public mental illness hospital.

____ 8. I give permission to the **Healthy Families Program** to check my family income, health coverage, immigration status of the person(s) I am applying for, that all persons I am applying for on this application live in California, and all other facts on this application.

____ 9. I agree to pay the program's family monthly premium for six (6) months. I understand that if I do not pay this premium, I or the person(s) I am applying for cannot be a member of the **Healthy Families Program** and will be disenrolled. Any **Healthy Families Program** services I, or the person(s) I am applying for, need to use after the date of the last monthly premium will be my financial responsibility.

____ 10. I declare that I will call or write to the **Healthy Families Program** within one month (30 days) if there is a change in address or mailing address for me or the person(s) I am applying for.

Part B: Application for the Healthy Families Program *(continued)*

Please fill out both sides of this form to continue your application for the Healthy Families Program.

Notice: Questions about citizenship/immigration status apply to the children — not the parents.

SECTION 4: Citizenship/Immigration Status

- *Please indicate the status of each person applied for, by checking (✔) a box below.*
- *If you check a box in Part II or Part IV, check a box in Part V also if it applies.*
- *Proof must be submitted for each category checked in Part I, II, IV and V.*

Write names from Back of Part A, page 12 in boxes below.

	18 year old applying for self Last Name First Name	Child A Last Name First Name	Child B Last Name First Name	Child C Last Name First Name
Part I				
A Citizen or national of the United States (U.S.) *If you do not have the document now to prove status, you may submit it within 60 days from the date of enrollment.* (If you check this line for **all** persons you are applying for, you may go to Section 5.)				
Part II				
An alien lawfully admitted for permanent residence				
An alien who is granted conditional entry to the U.S. before April 1, 1980				
An alien paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least one year				
An alien who, or whose child, or who is the child of a person who has been battered or subjected to extreme cruelty in the United States by a spouse or parent, or by a spouse or parent's family member living in the same household.				
If yes, are any of the following conditions a direct result? You may check one or more.				
a) Loss of financial support due to separation from abuser.				
b) Need for medical attention or counseling, or became disabled.				
c) Sexual abuse resulted in a pregnancy				
d) Loss of medical coverage and/or health care services.				
Does the person applied for live in the same household as the abuser now?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Part III				
What date did each person who checked a box in Part II above, enter the U.S.?	Date	Date	Date	Date
Part IV				
An alien granted asylum				
A refugee admitted to the United States				
An alien granted withholding of deportation pursuant to INA Section243(h)				
An alien who is a Cuban/Haitian entrant				
Part V				
An alien who is a veteran, who is on active duty in the Armed Forces of the U.S., or who is a spouse, unremarried surviving spouse, or unmarried child of a veteran or person on active duty in the Armed Forces of the U.S.				
An alien admitted to the U.S. as an Amerasian immigrant				

Part B: Application for the Healthy Families Program *(continued)*

SECTION 5: Privacy Notification

The Information Practices Act of 1977 and the Federal Privacy Act require this Program to provide the following to individuals who are asked by Healthy Families to supply information:

- Personal and medical information requested is for subscriber identification and program administration purposes only. Program regulations under Title 10, CCR, Section 2699.6600 require that every individual furnish certain information when applying to the Healthy Families Program. Subscriber's information may be shared with State and local agencies involved in the administration of health programs.
- Information (including immigration status) about persons who do not become subscribers, will be used only for purposes of eligibility determination and program administration.
- Failure to furnish this information may result in the return of the application as incomplete.
- The following information on the application is not mandatory: social security number and ethnicity information (unless you are a native American Indian).
- An individual has a right to access records containing his/her personal information that are maintained by the Managed Risk Medical Insurance Board.
- The official responsible for maintaining the information is the Deputy Director of Eligibility and Enrollment, Managed Risk Medical Insurance Board, (1000 G Street, Room 450, Sacramento, California 95814). The Board may charge a small fee to cover the costs of duplicating this information.

SECTION 6: Signature

I declare that all individuals listed on this application will abide by the rules of participation, the utilization review process and the dispute resolution process of the participating plans in which the individual is enrolled. I understand that a dispute resolution process may include neutral binding arbitration and that I may be giving up my right to a jury or court trial to resolve any claim, asserted by me, my enrolled dependents, heirs, personal representatives, or someone with a relationship to us, against the participating plan, or against the employees, partners, or agents, of the participating plan. I further understand that some plans that require neutral binding arbitration also include malpractice claims as a type of claim that must be resolved by the arbitration process. I declare that I have reviewed the list of plans which require neutral binding arbitration which appears in the **Healthy Families Program Handbook**.

I, the applicant, certify that the information provided on this application is true and correct.

Signature of Applicant Required

X _____ Date: _____

Signature of Witness: (if applicant signed with a mark)

X _____ Date: _____

Part B: Mailing Instructions for the Healthy Families Program

You **must** send the following documents with your application:

1. **Proof of income you claimed on page 7 (send photocopies):**

- **Any of the following:**
  - *a)* Copies of employee pay stubs for the most recent one-month period (if not available a signed statement from your employer, stating your gross monthly income)
  - *b)* For self-employed: Previous year's income tax return (IRS Form 1040 — include Schedule C or last 3 month's profit & loss statements)
  - *c)* Award Letter or bank statements showing direct income deposits (for example, SSI, disability, retirement payments, etc.)

2. Child support and/or alimony/spousal support if you get it (copies of canceled checks or receipts or payment statement from District Attorney's Family Division), for one month
3. A cashier's check or money order payable to **Healthy Families Program** for the first month's premium. If you pay three (3) consecutive months of premiums, your fourth (4th) month of coverage is **FREE!**

   See the **Healthy Families Program Handbook**, to find out what your monthly premium will be.

Use the boxes below to be sure you have included everything

- ☐ Steps 1, 2 & 3
- ☐ Part A
- ☐ Part B
- ☐ Proof of Income (from item 1 above)
- ☐ Proof of child(ren)'s alien status
- ☐ Proof of child(ren)'s U.S. citizenship (If you do not have the document now, you can send it in within 60 days from the date of enrollment)
- ☐ Cashier's Check or Money Order

USE THE POSTAGE PAID PRE-ADDRESSED ENVELOPE PROVIDED IN THE CENTER OF THIS PACKET

Healthy Families Program, P.O. Box 138005, Sacramento, CA 95813-8005

REMEMBER: If you need help, you may call toll-free: 1-800-880-5305

You will be notified by mail of the status of your application within 20 days of the date that your application is received by the Healthy Families Program.

NOTE: *If you have given us permission on Part A of this application, and you do not qualify for* ***Healthy Families Program****, we will forward your application to the appropriate program.*

Part C: Application for the Medi-Cal Program

You can have other health insurance and still get Medi-Cal. If you are applying for Healthy Families, please read the Healthy Families Program Handbook.

For County Use Only

SECTION 1: Family Information

1. Does anyone in your family have other health, dental, or vision insurance now? ☐ No ☐ Yes
   If yes, who: _____
   If yes, name(s) of the insurance company:
   a) _____ b) _____ c) _____
2. Do you and your family live in and intend to remain (reside) in California? ☐ No ☐ Yes
3. Are you or any family member in the U.S. on a Visa or Border Crossing Card? ☐ No ☐ Yes
   If yes, who: _____
4. Have you or any family member ever been in U.S. military service? ☐ No ☐ Yes
   If yes, who: _____

SECTION 2: General Information

Answer the questions for persons wanting Medi-Cal. Your answers will not affect your eligibility.

1. Is any family member currently in a nursing home / hospital / board and care? ☐ No ☐ Yes
   If yes, who: _____
   Facility: _____ date entered _____
2. Do you or any family member have a physical / emotional problem that makes it difficult to work or take care of personal needs? ☐ No ☐ Yes
   If yes, who: _____
   Will the problem last at least one year? ☐ No ☐ Yes
3. Is the physical / emotional problem a result of an injury or accident? ☐ No ☐ Yes
   Has any family member filed a lawsuit because of a disability or emotional problem? ☐ No ☐ Yes
   Attorney name: _____ Attorney address: _____

SECTION 3: Do You Want Information On Other Programs?

1. Do you want more information about the Child Health and Disability Prevention (CHDP) program services that provide regular medical and dental check-ups for family members under the age of 21? ☐ No ☐ Yes
2. Do you want CHDP medical services? ☐ No ☐ Yes
3. Do you want CHDP dental services? ☐ No ☐ Yes
4. Do you need help making appointments or with transportation to CHDP services? ☐ No ☐ Yes

For Medi-Cal, call toll-free: 1-888-747-1222

Please sign the back. ▶

Part C: Application for the Medi-Cal Program *(continued)*

SECTION 4: Certification Of Applicant—Applicant Must Read And Initial Each Statement

_____1. I have read and received a copy of the Important Information for Persons Requesting Medi-Cal (MC 219) on pages 24-27.

_____2. I understand that all of the statements here, including benefits and income information, that I have made on this form and all supplemental forms are subject to investigation and verification.

_____3. I declare, to the best of my knowledge and belief that the information I have provided in this application and its supplemental form(s) is true and correct.

_____4. I understand that the county is required by law to keep any information I provide confidential.

_____5. I understand that information I give may be shared with state and local agencies involved in the administration of health programs.

SECTION 5: Signatures

1. Signature of Interpreter: _____ Date: _____

1a. Relationship to Applicant: _____ Telephone Number: _____

2. Signature of Person acting for Applicant: _____ Date: _____

2a. Relationship to Applicant: _____ Telephone Number: _____

3. Signature of Witness: (if applicant signed with a mark) _____ Date: _____

3a. Relationship to Applicant: _____ Telephone Number: _____

4. Signature of Person helping Applicant fill out the form: _____ Date: _____

4a. Relationship to Applicant: _____ Telephone Number: _____

I declare under penalty of perjury under the laws of the State of California that the answers I have given are correct and true to the best of my knowledge.

▶ **5. APPLICANT SIGNATURE X** _____ Date: _____

You must send additional forms and copies of proof with your Medi-Cal application.
See page 23 for acceptable examples of verification and mailing instruction.

Answers to the questions in this box will give us information that will make it possible for the federal government to help California pay for its health care programs. Your answers will not affect your eligibility.

Do you have more than one car?	☐ No	☐ Yes
Do you have more than $3,150 cash in bank accounts?	☐ No	☐ Yes

MC 13 Mail-In: Medi-Cal Statement of Citizenship, Alienage, and Immigration Status

SECTION A: Who Wants Medi-Cal?

Please list the first and last names of all persons who are applying for Medi-Cal:

Adult Applying for Medi-Cal	Child A	Child B	Child C
Last	Last	Last	Last
First	First	First	First

SECTION B: Citizenship/Immigration Status Declaration

For anyone applying for benefits, answer question 1 by checking (✔) a box.	Adult Applying for Self	Child A	Child B	Child C
1. Is the person applying a citizen or national of the United States? Citizens and nationals of the United States who meet all eligibility requirements may receive full Medi-Cal benefits. ***(If you checked yes on this line for all persons applying, go directly to section C, line 5.)***	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

See page 27 for Important information for Aliens who want Medi-Cal.

If anyone applying is an alien, please answer questions 2, 3, and 4 below (and question 5 if the person claims to be Permanently Residing in the U.S. Under Color of Law (PRUCOL)). If the answer is "No" to questions 2, 3, or 4 because those categories do not apply, your answer is confidential. This information can only be used for Medi-Cal purposes, and cannot be used by the INS for immigration enforcement unless you are committing fraud.

For anyone applying who is not a citizen or national of the United States, please answer questions 2, 3 and 4 (and question 5 if you claim to be PRUCOL) by checking (✔) a box.	Adult Applying for Self	Child A	Child B	Child C
2. Is the person applying an Amnesty alien with a valid and current I-688?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3. Is the person applying a lawful permanent resident?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. Is the person applying a PRUCOL (Permanently Residing in the U.S. Under Color of Law) alien?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5. If the person applying could get Medi-Cal benefits as a PRUCOL alien indicate the status that entitles him/her to benefits by checking (✔) a box below.				
a) A conditional entrant admitted to the United States before April 1, 1980	☐	☐	☐	☐
b) An alien paroled into the United States, including Cuban/Haitian entrants	☐	☐	☐	☐
c) An alien subject to an Order of Supervision	☐	☐	☐	☐
d) An alien granted an indefinite stay of deportation	☐	☐	☐	☐
e) An alien granted an indefinite voluntary departure	☐	☐	☐	☐
f) An alien on whose behalf an immediate relative petition (INS form I-130) has been approved and who is entitled to voluntary departure	☐	☐	☐	☐
g) An alien who has properly filed an application for lawful permanent resident status (continued on Page 22)	☐	☐	☐	☐

Please complete Section C and D on the other side of this form. ▶

PRUCOL Status continued:	Adult Applying for Self	Child A	Child B	Child C
h) An alien granted a stay of deportation for a specified period	☐	☐	☐	☐
i) An alien granted asylum	☐	☐	☐	☐
j) A refugee admitted to the U.S. since April 1, 1980	☐	☐	☐	☐
k) An alien granted voluntary departure who is awaiting issuance of a visa	☐	☐	☐	☐
l) An alien in deferred action status	☐	☐	☐	☐
m) An alien who entered and has continuously resided in the U.S. since before January 1, 1972 who would be eligible for an adjustment of status to lawful permanent resident pursuant to INA Section 249 (eligible as a Registry alien)	☐	☐	☐	☐
n) An alien granted a suspension of deportation whose departure INS does not contemplate enforcing	☐	☐	☐	☐
o) An alien granted a withholding of deportation pursuant to INA Section 243(h)	☐	☐	☐	☐
p) An alien, not in one of the above categories, who can show that: (1) INS knows he/she is in the United States, and (2) INS does not intend to deport him/her, either because of the person's status category or individual circumstances	☐	☐	☐	☐

SECTION C: Information on Applicants

Answer the questions for persons who want Medi-Cal.

For anyone who is a citizen or national of the United States, complete only line 5 below.

For anyone applying for benefits who answered yes to questions 2, 3 or 4 in Section B, complete all information on lines 1-5 below.

	Applicant (Self)	Child A
1. Alien registration number and/or Alien Admission (INS Form I-94) number		
2. Date first entered the U.S.		
3. Name when first entered the U.S.		
4. Citizen of what country		
5. Born where		

	Child B	Child C
1. Alien registration number and/or Alien Admission (INS Form I-94) number		
2. Date first entered the U.S.		
3. Name when first entered the U.S.		
4. Citizen of what country		
5. Born where		

SECTION D: Signatures

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

▶

Signature of the Applicant or of Person legally authorized to act for all applicants listed on the front of this form. Date

Part C: Mailing Instructions for Medi-Cal

You **must** send the following documents with your application. Send photocopies only, do not send originals.

1. **Proof of income you claimed on pages 7 and 8:**

   Acceptable examples:

   - Copies of employee pay stubs for the most recent one-month period (if not available, a signed statement from your employer stating your gross monthly income by pay period)
   - For self-employed: Previous year's income tax return (IRS Form 1040 — include Schedule C or last 3 month's profit & loss statements)
   - Award letter or bank statements showing direct income deposits (for example, SSI, disability, retirement payments, etc.)
   - Child support and/or alimony/spousal support if you get it (canceled checks, receipts or payment statement from District Attorney's Family Division)
   - Any other document that may prove your income

2. **Proof of deductions you claimed on page 9:**

   - Work expense (no proof needed)
   - Child and dependent care receipts or canceled checks
   - Court ordered alimony/spousal support you pay (canceled checks or pay stubs showing support deductions)
   - Court ordered child support you pay (canceled checks or pay stubs showing support deductions)

3. **Evidence of residency. Send a photocopy of one of the following:**

   - Current rent, mortgage or utility receipt in applicant's name
   - Current and valid California driver's license or California Identification Card issued by the Department of Motor Vehicles
   - Current and valid motor vehicle registration in applicant's name with current address of applicant
   - A document showing the applicant is employed in California
   - A document showing the applicant has registered with an employment service in California
   - Evidence that the applicant has enrolled his or her children in school in California
   - Evidence that the applicant is receiving public assistance other than Medi-Cal in California
   - Evidence that the applicant has registered to vote in California
   - If you do not have one of the items listed above, you can give any other evidence you have

4. **Proof of alien status:**

   - INS document that shows immigration status

CHECK THE BOXES BELOW TO BE SURE YOU HAVE INCLUDED EVERYTHING

- ☐ Steps 1, 2 & 3
- ☐ Part A
- ☐ Part C
- ☐ MC 13
- ☐ CA 2.1 and CA 2.1 (Q)
  (Required if one parent is absent or there are unmarried parents in the home. Available at your local county welfare office or community organization.)
- ☐ Proof of identity of applicant
- ☐ Proof of income (from item 1 above)
- ☐ Proof of deductions (from item 2 above)
- ☐ Proof of pregnancy from a doctor or clinic
- ☐ Evidence of residency
- ☐ Proof of alien status

Be sure to use the Medi-Cal postage paid pre-addressed envelope provided in the center of this packet.
Don't forget to check the box next to the county you live in on the back of the envelope.

REMEMBER: If you need help, you may call toll-free: 1-888-747-1222.
You will be notified by mail of the status of your application.

NOTE: *If you have given us permission on Part A of this application and it is found that your income would give you or your children share-of-cost Medi-Cal, we will forward your application to the Healthy Families or AIM Program.*

MC 219: Important Information for Persons Requesting Medi-Cal

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you to decide if you, or the persons you represent, can get Medi-Cal benefits. You must provide these facts to get Medi-Cal benefits. The information will be used:

1. By the county welfare department to establish first time and ongoing Medi-Cal eligibility.
2. By Electronic Data Systems (EDS) to process claims and make Benefits Identification Cards (BICs).
3. By the United States (U.S.) Department of Health and Human Services to make audit and quality control reviews and verify Medicare Buy-In and Social Security Numbers (SSNs).
4. To verify alien status with the U.S. Immigration and Naturalization Service (INS) only for aliens who claim to be lawfully admitted for permanent residence or Permanently Residing in the U.S. Under Color of Law (PRUCOL) or Amnesty Aliens with a valid and current I-688 card. The information the INS receives can only be used to determine Medi-Cal eligibility, and cannot be used for immigration enforcement unless you are committing fraud.
5. By medical services providers and health maintenance organizations to certify eligibility.
6. To identify health insurance coverage and take recovery actions.

MEDI-CAL APPLICANT/BENEFICIARY RIGHTS, RESPONSIBILITIES, AND UNDERSTANDINGS

I have the right to:

1. Ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
2. Be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
3. Apply as a disabled person if I think I am disabled.
4. Be told about the rules for retroactive Medi-Cal eligibility.
5. Apply for Medi-Cal and to be told **in writing** whether I qualify for any Medi-Cal program.
6. Review Medi-Cal program rules and regulation manuals if I want to question the basis on which my eligibility is approved or denied.
7. Have all facts that I give to the county welfare department kept in the strictest confidence and to look at those facts during regularly scheduled office hours.
8. Receive an immediate need card, **when possible and eligible**, if I have a medical emergency or I am pregnant.
9. Receive Medi-Cal, as authorized, while my satisfactory immigration status is being documented and verified, if I am otherwise eligible. **Aliens who are lawfully admitted for permanent residence or PRUCOL or Amnesty Aliens with a valid and current I-688 card are in a satisfactory immigration status.**
10. Be told about the Child Health and Disability Prevention Program and the Special Supplement Food Program for Women, Infants, and Children, and to ask for help in receiving those services.
11. Ask for and receive information about the Family Planning Program and be told if I am eligible for those services.
12. Speak to a social worker about other public or private services or resources that I can get.
13. Be told about Medi-Cal Health Care Plans that my family and I can join to get a doctor and other medical care, and to choose the option I prefer.
14. Lower my share of cost by providing past unpaid medical bills (that I still owe).
15. Reduce my property reserve to within the Medi-Cal property limit by the last day of a month for which I want Medi-Cal, including the month I apply and to be told how I may spend my excess property.

Important Information for Persons Requesting Medi-Cal *(continued)*

16. Divide countable (non-exempt) community (MY SPOUSE's AND MY) property by written agreement into equal shares of separate property if either of us entered a long-term care (LTC) facility before September 30, 1989.
17. Keep a certain amount of countable separate and community property if I enter an LTC facility on or after January 1, 1990. My spouse and I have the right to be told the amount.
18. Have a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services, except actions relating to the Health Insurance Premium Payment (HIPP) and Employer Group Health Plan (EGHP) programs. If I want a state hearing to appeal the decision, I must ask for it within **90 days** of the date the Notice of Action (NOA) was mailed to me. If I do not receive a NOA, I must request a hearing within **90 days** from the date I discover the action (or inaction) with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to ask for a hearing is to contact the nearest county welfare department.

I HAVE THE RESPONSIBILITY TO TELL MY COUNTY REPRESENTATIVE WITHIN TEN (10) DAYS WHENEVER:

1. Income received by me or any member of my family increases, decreases, starts, or stops. This includes income from Social Security Administration (SSA), loans, settlements, or any other source.
2. I plan to change or have already changed my place of residence or mailing address.
3. A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
4. An absent parent returns to the home.
5. I or a member of my family gives birth, becomes pregnant, or ends a pregnancy.
6. I, my spouse, or any member of my family enters or leaves a nursing home or an LTC facility.
7. I receive, transfer, give away, or sell real or personal property (including money) or when someone gives me or a member of my family such things as a car, house, insurance payments, etc.
8. I have any expenses that are paid for by someone other than myself.
9. I or a member of my family gets a job, changes jobs, or no longer has a job.
10. I have a change in expenses related to my job or education. (For example: child care, transportation, etc.)
11. I or a member of my family becomes physically or mentally impaired so that I/he/she cannot get or keep a job (this would include a child in the family who may not be able to get a job in the future due to the impairment).
12. I or a member of my family applies for disability benefits with the SSA, Veterans Administration, or Railroad Retirement.
13. One of my children drops out of school or returns to school.
14. There is a change in the citizenship/immigration status of any family member applying for or receiving Medi-Cal.
15. Health insurance coverage for me or a member of my family changes.

I HAVE THE RESPONSIBILITY TO:

1. Complete and return a status report by the date required when requested by the county.
2. Give proof that I am a resident of California.
3. Make a declaration about my citizenship/immigration status.
4. Provide an SSN for myself and/or for any member of my family who has an SSN and wants Medi-Cal benefits. If I am a U.S. citizen, a U.S. national, or an alien in a satisfactory immigration status, I must apply for an SSN and provide it to the county if I do not already have one. If I need to apply for an SSN, I can get help from my eligibility worker, but I must work with the SSA to clear up any questions or my Medi-Cal will be denied or stopped. (Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.)

Important Information for Persons Requesting Medi-Cal *(continued)*

5. Apply for any income that may be available to me or any member of my family.
6. Apply for Medicare benefits if I am blind, disabled, have End Stage Renal Disease, or am 64 years and 9 months of age or older and eligible. I am responsible for telling my providers that I have both Medi-Cal and Medicare coverage.
7. Apply for and enroll in any health insurance if that is available to me and my family at no cost. I have the responsibility to remain enrolled in the health plan when Medi-Cal approves payment of plan premiums by the State of California.
8. Report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use, including Medicare. If I willfully fail to give this fact, I may be guilty of a criminal offense, or may be billed by my provider.
9. Go to my health care plan (such as Kaiser, CHAMPUS, or a Medicare HMO) for medical care. (Medi-Cal will not pay for any services covered by the plan.)
10. Give any insurance payments I receive to the State if Medi-Cal has already paid for my care.
11. Go to a presentation, if presentations are given, and make a written choice, or answer if received by mail, about how I want to get my Medi-Cal benefits. If I do not go and make a choice, or choose by mail, my eligible family members and I may be signed up in a Medi-Cal Health Care Plan near my home.
12. Sign and date my BIC when I get it and ensure it is used only to get necessary health care for myself or eligible family members.
13. Take my BIC to my medical provider when I am sick or have an appointment. In emergencies when the BIC is not in hand, I must get the BIC to the medical provider when possible.
14. Report to the county department when I receive health care services because of an accident or injury caused by another person's action or failure to act, for which Medi-Cal has been, or may be billed.
15. Cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to through an absent parent.
16. Cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be stopped.

I UNDERSTAND THAT:

1. Failure to give necessary facts or deliberately giving false facts can result in Medi-Cal benefits being denied or stopped. My case may also be investigated for suspected fraud.
2. The facts I give will be checked by computer with facts given by employers, banks, SSA, Franchise Tax Board, welfare, and other agencies. I will have the right to give proof to correct any facts which are found to be wrong.
3. Aliens who are not in a satisfactory immigration status and do not have an SSN can get ***restricted*** Medi-Cal without applying for an SSN if they meet all the rules.
4. Immigration status data given as part of the Medi-Cal application is confidential.
5. Based on my income, I will have to pay or be billed for part of my medical expenses before I can get Medi-Cal.
6. If I do not report changes promptly, and because of this, receive Medi-Cal benefits that I am not eligible for, I may have to repay the State Department of Health Services.
7. If I am receiving Medi-Cal based on disability and I apply for disability benefits from the SSA, and the SSA denies my disability claim, my Medi-Cal may be stopped. If I appeal my SSA denial right away, my Medi-Cal will continue until the SSA makes a final decision. If the SSA allows my claim, then my Medi-Cal benefits will continue. If the SSA does not allow my claim, then my Medi-Cal benefits will stop.
8. As a condition of Medi-Cal eligibility, all rights to medical support and/or payment for medical services for myself and any eligible persons that I have legal responsibility for, are automatically assigned to the State.
9. If medical support is court-ordered from an absent parent for my children, the insurance carrier must allow me to enroll and provide benefits to my children without the absent parent's consent.

Important Information for Persons Requesting Medi-Cal *(continued)*

10. If I don't apply for or keep no-cost health coverage or state-paid coverage, my Medi-Cal benefits and/or eligibility will be denied or stopped.
11. When I apply for Medi-Cal, I will be evaluated for potential eligibility under other medical assistance programs, including the HIPP and EGHP programs.
12. If I ask a Medi-Cal provider for any services not covered by my non-Medi-Cal health insurance plan, I must give the medical provider a written statement from my health plan saying it does not offer the Medi-Cal-covered services.
13. Medi-Cal providers cannot collect insurance copayment, coinsurance, or deductibles from me unless the payment is used to meet my Medi-Cal share of cost and/or copayment.
14. If I am admitted to a nursing facility and I have no intention of returning to my home, the State may impose a lien against my property.
15. After my death, the State has the right to seek reimbursement from my estate for all Medi-Cal benefits I received after age 55 unless I have a surviving spouse (during his or her lifetime), minor children, blind or permanently and totally disabled children, or it would create a hardship for my heirs.
16. After the death of my surviving spouse, the State has the right to claim from the part of his or her estate received from me, all Medi-Cal benefits I received after age 55 up to the amount of property my spouse received from my estate.

Important Information for Aliens who want Medi-Cal

- **Citizens and nationals of the United States who meet all eligibility requirements** may receive full Medi-Cal benefits.
- **Aliens who meet all eligibility requirements** may receive either full Medi-Cal benefits (if they are in a satisfactory immigration status) or restricted benefits limited to emergency and pregnancy-related services (if they are not in a satisfactory immigration status).
- **Satisfactory immigration status and full Medi-Cal benefits for aliens:** Federal and state law provide that *full* Medi-Cal benefits may be received only by aliens who are in a satisfactory immigration status and who meet all eligibility requirements **including California residency.** Aliens are in a satisfactory immigration status if they are amnesty aliens with valid and current lawful temporary resident cards (I-688) or lawful permanent residents or permanently residing in the U.S. under color of law (PRUCOL). **The 16 PRUCOL categories are listed in SECTION B, question 5 on the MC 13 Mail-In form on pages 21 and 22.**
- **Battered aliens:** If an alien or his/her child has been battered or subjected to cruelty in the U.S., he/she should tell the county eligibility worker. The eligibility worker can help him/her apply for all benefits he/she may be eligible to receive.
- **Documented aliens not in a satisfactory immigration status** who meet all eligibility requirements, including California **residency,** may receive restricted benefits (limited to emergency and pregnancy related services).
- **Undocumented aliens who meet all eligibility requirements, including California residency,** may receive restricted benefits (limited to emergency and pregnancy-related services).
- **Citizenship/Immigration status information:** Every person requesting Medi-Cal is required to provide information about his/her citizenship or immigration status. Immigration status information provided as part of the Medi-Cal application is confidential and cannot be used by the INS for immigration enforcement unless you are committing fraud.
- **Alien status documents and verification requirements:** Aliens who claim to be in a satisfactory immigration status for Medi-Cal purposes must present INS documents that show their immigration status if they have an INS document or are eligible to obtain one. Aliens who claim to be in a satisfactory immigration status, but who cannot obtain an INS document or replacement receipt (for example, aliens in the last PRUCOL category indicated in SECTION B, Question 5 on the MC 13 Mail-In form on page 22), should submit other evidence establishing their immigration status. INS documents will be verified by the INS. Aliens who do not have these documents with them, or who have unreadable documents, may bring us receipts which show that they have applied for replacements. Aliens will have 30 days to do this, or until their Medi-Cal application is ruled on, whichever is longer. If the alien is otherwise eligible, Medi-Cal will be issued during this period and while the submitted documentation is being verified by the INS. If none of the documents contains the applicant's photograph, they must show us an identity document which establishes that the applicant is the person named in the documents.

ETHNIC CODES

For Application Part A:

Giving your Ethnic Code is optional for Healthy Families unless you are an American Indian.

1	White
2	Hispanic
3	Black/African American
4	Asian
5a	American Indian
5b	Alaskan Native
7	Filipino
A	Amerasian
C	Chinese
H	Cambodian
J	Japanese
K	Korean
M	Samoan
N	Asian Indian
P	Hawaiian
R	Guamanian
T	Laotian
V	Vietnamese
Z	Other

NOTES

For help in your language...

Please call toll-free 1 (888) 747-1222

For English information, Press 1 ..... 1 English

Si desea información en español,
por favor llame al número que figura más arriba y Oprima el 2 ..... 2 Spanish

**Muốn được giúp đỡ bằng tiếng Việt,
xin gọi số trên và Bấm số** 3 ..... 3 Vietnamese

สนทนาเป็นภาษาอังกฤษ, กรุณากดหมายเลข 4 ..... 4 Cambodian

Yog koj xav paub xov ntxiv hais ua lus Hmoob, thov koj hu tus xov tooj teev
los saum toj no, tom qab ntawd, koj mam nias tus nabnpawb 5 ..... 5 Hmong

**Հայերեն տեղեկատվություն ստանալու համար
սեղմեք համապատասխան թիվը հետո հետևյալ համարով** 6 ..... 6 Armenian

如需粵語資料，請撥上列號碼並按 7 ..... 7 Cantonese

ສຳລັບຂໍ້ມູນເປັນພາສາລາວ, ກະລຸນາໂທຕາມເບີລຸ່ມນີ້ແລ້ວກົດ 8 ..... 8 Lao

**Для получения информации на русском
языке звоните, пожалуйста, по выше
указанному телефону и нажмите кнопку** 9 ..... 9 Russian

**برای کسب اطلاعات به زبان فارسی با شماره فوق الذکر تماس بگیرید و
شماره ۱۰ را فشار دهید.** ..... 10 Farsi

For TDD Service, please call toll-free: 1 (800) 952-8349